PIC WISCONSIN
A ProAssurance Company

Physicians Insurance Company of Wisconsin, Inc.

800/282-6242
Fax 205/802-4775

December 21, 2007

Ms. Gayle Neuman
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767

FEW# 39-1567580 ✓

RE: Physicians Insurance Company of Wisconsin, Inc. - NAIC # 23400
A ProAssurance Company
Line of Business – Medical Malpractice – Class 2 Clause (c)
Dental Professional Liability RATE DECREASE
Company Filing #IL-DPL-0208

Dear Ms. Neuman:

Please find enclosed for your review and approval a dental professional liability rate filing for PIC Wisconsin to be effective February 15, 2008. The Filing Memorandum and its exhibits should explain the rate development and its impact.

The General Rule and Rating Manual for Healthcare Providers Professional Liability, which is currently on file with your department, applies to dentists as well as physicians and other healthcare providers and no changes are being made other than what is located in the Filing Memorandum and exhibits.

If you have any questions during the review process, please do not hesitate to contact me. If this filing is acceptable, please return one copy of the filing with your stamp of approval in the postage paid envelope that is enclosed for your convenience. If you have any questions regarding this filing, please contact me at (800) 282-6242, ext. 4426, or e-mail me at lgoodwin@proassurance.com.

Sincerely,

LaQuita B. Goodwin

LaQuita B. Goodwin
Compliance Specialist

Enclosures

1-0
MEM
RATE
Jeh

Section 754.EXHIBIT A Summary Sheet (Form RF-3)

FORM (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 2/15/2008.

	(1) Coverage	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
1.	Automobile Liability Private Passenger		
	Commercial		
2	Automobile Physical Damag Private Passenger		
	Commercial		
3.	Liability Other Than Auto		
4.	Burglary and Theft		
5.	Glass		
6.	Fidelity		
7.	Surety		
8.	Boiler and Machinery		
9.	Fire		
10.	Extended Coverage		
11.	Inland Marine		
12.	Homeowners		
13.	Commercial Multi-Peril		
14.	Crop Hail		
15.	Other Medical Malpractice Life of Insurance	6,073,810	-0.03%

Does filing only apply to certain territory (territories) or certain Classes? If so, specify: No

Brief description of filing. (If filing follows rates of an advisory Organization, specify organization): Revised dentists increased limit and excess factors.

*Adjusted to reflect all prior rate changes.
**Change in Company's premium level which will result from application of new rates.

DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
RECEIVED
APR 18 2008
SPRINGFIELD, ILLINOIS

Physicians Insurance Company of Wisconsin, Inc.
Name of Company

LaQuita B. Goodwin - Compliance Specialist
Official – Title

Neuman, Gayle

From: Goodwin, LaQuita [LGoodwin@proassurance.com]
Sent: Wednesday, February 24, 2010 9:02 AM
To: Neuman, Gayle
Subject: RE: PIC Wisconsin - Rate/Rule Filings #IL-DPL-0208 and #PIC0608

Ms. Neuman,

Yes, both filings were implemented on the requested effective dates.

Thank you for your assistance with these filings.

LaQuita B. Goodwin
Compliance Specialist, Legal Dept.
ProAssurance Companies
205.877.4426 Direct
205.414.2887 Fax
Birmingham, Alabama

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, February 24, 2010 7:47 AM
To: Goodwin, LaQuita
Subject: PIC Wisconsin - Rate/Rule Filings #IL-DPL-0208 and #PIC0608

Ms. Goodwin,

The Department has now completed its review of the filings referenced above. The Director signed off on each filing on February 22, 2010. Originally, PIC Wisconsin requested effective dates of February 15, 2008 and June 15, 2008. Were the filings put in effect on those dates? Your prompt response is appreciated.

Gayle Neuman
Illinois Department of Insurance
Property & Casualty Compliance
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Department's website at www.insurance.illinois.gov.

P. erty & Casualty Transmittal Doc ent

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only
	a. Date the filing is received:
	b. Analyst:
	c. Disposition:
	d. Date of disposition of the filing:
	e. Effective date of filing:
	New Business
	Renewal Business
	f. State Filing #:
	g. SERFF Filing #:
	h. Subject Codes

RECEIVED
DEC 24 2007
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

3.	Group Name	Group NAIC #
	ProAssurance Group	2698

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	Physicians Insurance Company of Wisconsin, Inc.	Wisconsin	23400	39-1567580	

5.	Company Tracking Number	IL-DPL-0208

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	LaQuita B. Goodwin 100 Brookwood Place Birmingham, AL 35209	Compliance Specialist	205-877-4426	205-414-2887	lgoodwin@proassurance.com

7.	Signature of authorized filer	LaQuita B. Goodwin
8.	Please print name of authorized filer	LaQuita B. Goodwin

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	11.0 – Medical Malpractice			
10.	**Sub-Type of Insurance (Sub-TOI)**	11.0007 – Dentists and Oral Surgeons			
11.	**State Specific Product code(s)**(if applicable)[See State Specific Requirements]				
12.	**Company Program Title** (Marketing title)	Healthcare Providers Professional Liability			
13.	**Filing Type**	[ ] Rate/Loss Cost [ ] Rules [**X**] Rates/Rules [ ] Forms [ ] Combination Rates/Rules/Forms [ ] Withdrawal[ ] Other (give description)			
14.	**Effective Date(s) Requested**	New:	2/15/2008	Renewal:	2/15/2008
15.	**Reference Filing?**	[ ] Yes [X] No			
16.	**Reference Organization** (if applicable)				
17.	**Reference Organization # & Title**				
18.	**Company's Date of Filing**	December 21, 2007			
19.	**Status of filing in domicile**	[ ] Not Filed [**X**] Pending [ ] Authorized [ ] Disapproved			

Prope y & Casualty Transmittal Do ment—

20.	This filing transmittal is part of Company Tracking #	IL-DPL-0208

21.	**Filing Description** [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

Please find enclosed for your review and approval a dental professional liability rate filing for PIC Wisconsin to be effective February 15, 2008. The Filing Memorandum and its exhibits should explain the rate development and its impact.

The General Rule and Rating Manual for Healthcare Providers Professional Liability, which is currently on file with your department, applies to dentists as well as physicians and other healthcare providers and no changes are being made other than what is located in the Filing Memorandum and exhibits.

22.	**Filing Fees** (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: N/A
Amount:

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	**IL-DPL-0208**
2.	**This filing corresponds to form filing number** (Company tracking number of form filing, if applicable)	

☐ Rate Increase ☒ Rate Decrease ☐ Rate Neutral (0%)

3.	**Filing Method (Prior Approval, File & Use, Flex Band, etc.)**	File & Use

4a. Rate Change by Company (As Proposed)

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)
PIC Wisconsin	N/A	-0.20%	-$1,794	895	897,014	0%	-4.30%

4b. Rate Change by Company (As Accepted) For State Use Only

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)

		COMPANY USE	STATE USE
5a	**Overall percentage rate indication (when applicable)**		
5b	**Overall percentage rate impact for this filing**		
5c	**Effect of Rate Filing – Written premium change for this program**		
5d	**Effect of Rate Filing – Number of policyholders affected**		

6.	**Overall percentage of last rate revision**	15.0%
7.	**Effective Date of last rate revision**	7/1/2004 under Company Filing # DPL Rates2004IL
8.	**Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)**	File & Use

9.	Rule # or Page # Submitted for Review	Replacement or withdrawn?	Previous state filing number, if required by state
01	N/A	[ ] New [ ] Replacement [ ] Withdrawn	
02		[ ] New [ ] Replacement [ ] Withdrawn	

Neuman, Gayle

From: Goodwin, LaQuita [LGoodwin@proassurance.com]
Sent: Friday, April 18, 2008 3:30 PM
To: Neuman, Gayle
Subject: RE: Dental Professional Liability - Rate/Rule Filing #IL-DPL-0208
Attachments: 0212_001.pdf

Ms. Neuman,

If you require a hard copy of this response, please let me know.

Thanks.

LaQuita B. Goodwin
Compliance Specialist
Legal Department
ProAssurance Professional Liability Group
Medical Assurance/ProNational/NCRIC/PIC WISCONSIN
Woodbrook Casualty/Red Mountain Casualty
Birmingham, Alabama
(205) 877-4426 or (800) 282-6242, ext. 4426 Fax (205) 414-2887

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, April 16, 2008 1:14 PM
To: Goodwin, LaQuita
Subject: Dental Professional Liability - Rate/Rule Filing #IL-DPL-0208

Ms. Goodwin,

We are in receipt of the above referenced filing submitted by your letter dated December 21, 2007.

On the Filing Memorandum, it states there is an overall impact of -0.2%. Therefore, you are required to submit a RF-3 Summary Sheet for this rate change. There would be pages in the manual with the corresponding changes. You are required to identify all changes being made. Additionally, you are required to provide a copy of the entire manual section with the revisions being submitted made. We require you certify that nothing else in the filing has changed from what was previously filed, except for the changes brought to our attention in this filing.

We request receipt of your response by no later than April 30, 2008.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

PIC WISCONSIN
A ProAssurance Company

Physicians Insurance Company of Wisconsin, Inc.

800/282-6242
Fax 205/802-4775

VIA EMAIL: Gayle.Neuman@illinois.gov

April 18, 2008

Ms. Gayle Neuman
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767

RE: Physicians Insurance Company of Wisconsin, Inc. - NAIC # 23400
A ProAssurance Company
Line of Business – Medical Malpractice – Class 2 Clause (c)
Dental Professional Liability
Company Filing #IL-DPL-0208

Dear Ms. Neuman:

In response to your email dated April 16, 2008, please find enclosed a RF-3 Summary Sheet for this filing. Also enclosed is the Rating Factors page, which is being revised, and the Excess Factors Page, which is new.

As mentioned in the Filing Memorandum, limits above $1M/$3M will now be shown on our policies and forms as an excess layer above primary limits of $1M/$3M and limits that are not available as a primary and excess layer will no longer be offered.

Please note that the two enclosed pages are the Rating Section of the underwriting manual and rates can be derived by using the formula located at the bottom of the Rating Factors page. There are no other changes to our rates or rating rules, other than the aforementioned pages, since Filing # DPL Rates 2004 IL, effective July 1, 2004.

If you have any questions regarding this filing, please contact me at (800) 282-6242, ext. 4426, or e-mail me at lgoodwin@proassurance.com.

Sincerely,

LaQuita B. Goodwin
Compliance Specialist

Enclosures

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, Kathryn A. Neville, a duly authorized officer of Physicians Insurance Company of Wisconsin, Inc., am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing. I also certify that all changes made were disclosed, no written statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate.

I, Howard H. Friedman, a duly authorized actuary of Physicians Insurance Company of Wisconsin, Inc., am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

Kathryn A. Neville, Vice President — 4-28-08

Signature and Title of Authorized Insurance Company Officer — Date

Howard H. Friedman, ACAS, MAAA, Senior Vice President — 4/28/08

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 39-1567580 Filing Number IL-DPL-0208

Insurer's Address 100 Brookwood Place

City Birmingham State Alabama Zip Code 35209

Contact Person's:

-Name and E-mail LaQuita B. Goodwin, Compliance Specialist – lgoodwin@proassurance.com

-Direct Telephone and Fax Number (205) 877-4426 – Fax (205) 414-2887

Neuman, Gayle

From: Goodwin, LaQuita [LGoodwin@proassurance.com]
Sent: Thursday, May 01, 2008 9:15 AM
To: Neuman, Gayle
Subject: RE: PIC Wisc - Dental Professional Liability - Rate/Rule Filing #IL-DPL-0208
Attachments: 0338_001.pdf; Final copy of PIC manual.pdf; Rating Factors Page.PDF

Good morning, Gayle.

I have attached the response to your concerns. I do want to point out one additional concern about the page numbering that I didn't address in my cover letter. Pages 1 - 11, General Rules, and Pages A - N are standard for all states. The state exceptions for all states begins after that, which is why the Illinois Program pages begins with Manual Page W. Changing the page numbers at this time would require me to change any references to pages throughout the entire manual.

If you have any other questions or concerns, please let me know.

Thanks.

LaQuita B. Goodwin
Compliance Specialist
Legal Department
ProAssurance Professional Liability Group
Medical Assurance/ProNational/NCRIC/PIC WISCONSIN
Woodbrook Casualty/Red Mountain Casualty
Birmingham, Alabama
(205) 877-4426 or (800) 282-6242, ext. 4426 Fax (205) 414-2887

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, April 24, 2008 11:09 AM
To: Goodwin, LaQuita
Subject: PIC Wisc - Dental Professional Liability - Rate/Rule Filing #IL-DPL-0208

Ms. Goodwin,

We are in receipt of your response dated April 18, 2008. We have the following questions/issues:

1. 215 ILCS 5/155.18 states it shall be certified in this filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

2. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If a stat agency is used, please indicate which one?

3. Where is territory 1 and 2 defined?

4. All companies writing medical liability insurance shall file with the Secretary or Director a plan to offer each medical liability insured the option to make premium payments, in at least quarterly installments. For purposes of this requirement, insurers may, but are not required to, offer such premium installment plans to insureds whose annual premiums are less than $500, or for premium for any extension of a reporting period. Quarterly installment premium payment plans subject to this Section shall be included in the initial offer of the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment plan provisions shall be contained in the filed rate and/or rule manual in a section

entitled, "Quarterly Installment Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement. All quarterly installment premium payment plans shall include the minimum standards listed below. Insurers may provide for quarterly installment premium payment plans that differ from these minimum standards, as long as such plans have terms that are at least as or more favorable than those listed below.

a) An initial payment of no more than 40% of the estimated total premium due at policy inception;

b) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

c) No interest charges;

d) Installment charges or fees of no more than 1% of the total premium or $25.00, whichever is less;

e) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

5. It would be helpful if all pages were numbered. You could restart numbering on pages that pertain only to Illinois with IL-1 for example.

6. As most pages under this dental section were filed in 1997, we request you file an updated copy with page numbering and highlight any changes made being made since they were last filed.

We request receipt of your response by no later than May 1, 2008.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

PIC WISCONSIN
A ProAssurance Company

Physicians Insurance Company of Wisconsin, Inc.

800/282-6242
Fax 205/802-4775

VIA EMAIL: Gayle.Neuman@illinois.gov

May 1, 2008

Ms. Gayle Neuman
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767

RE: Physicians Insurance Company of Wisconsin, Inc. - NAIC # 23400
A ProAssurance Company
Line of Business – Medical Malpractice – Class 2 Clause (c)
Dental Professional Liability
Company Filing #IL-DPL-0208

Dear Ms. Neuman:

In response to your email dated April 24, 2008, please find enclosed a certification that the rates in this filing are based on sound actuarial principles and are not inconsistent with the company's experience. Also, please note that the statistical agency that we utilize for ProAssurance Group is ISO.

Territory 1 is Cook County and Territory 2 is all other counties. I have updated the Rating Factors page to include this description.

I have also amended the Illinois Program manual pages to include the Quarterly Installment Options, which was approved by your department for our affiliate company, ProNational Insurance Company, under Filing Number HCP092305. Please refer to Manual Page X.1.

At this time, it would be best if the page numbering were to remain as is until we convert to the standard ProAssurance format that we presently utilize for the other companies. It is our intention to convert to the new format soon.

The Healthcare Providers Professional Liability General Rule and Rating Manual is used for physicians, surgeons, dentists, allied health professionals, etc. I provided a complete copy of this manual, excluding the addition of the Quarterly Installment Options, in response to the Medical Professional Liability under Company Filing # PIC-MPL-1207 on April 22, 2008. I am also providing a copy of this manual, with the new rule, for this dental filing.

I believe you will find everything in order. If you have any questions regarding this filing, please contact me at (800) 282-6242, ext. 4426, or e-mail me at lgoodwin@proassurance.com.

Sincerely,

LaQuita B. Goodwin

LaQuita B. Goodwin
Compliance Specialist

Enclosures

Neuman, Gayle

From: Neuman, Gayle
Sent: Monday, May 05, 2008 1:26 PM
To: 'Goodwin, LaQuita'
Subject: Dental Filing #IL-DPL-0208

Ms. Goodwin,

We are in receipt of your e-mail response dated May 1, 2008.

We are fine with the page numbering you have - and appreciate the explanation given. However, on the Illinois rates pages, there is no page numbering. It helps our assistants when replacing pages in the manual.

The attachments on your May 1, 2008 e-mail did not include the DENTAL manual pages, rather the healthcare providers pages. Therefore, please submit the pages for the dental section.

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

Neuman, Gayle

From: Neuman, Gayle
Sent: Wednesday, May 14, 2008 8:21 AM
To: 'Goodwin, LaQuita'
Subject: RE: Request for extension to respond to filings

I will extend the due date until May 23, 2008.

Gayle Neuman
Division of Insurance

-----Original Message-----
From: Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]
Sent: Wednesday, May 14, 2008 8:04 AM
To: Neuman, Gayle
Subject: Request for extension to respond to filings

RE: Company Filing Numbers PIC-MPL-1207, IL-DPL-0208 and PIC0608

Good morning, Gayle.

You asked that we respond to your concerns on the aforementioned filings by May 15. I would like to respectfully request an additional week to respond. The Senior Underwriter will not return to the office until May 16. Please confirm extension by replying.

Thank you for your immediate attention to this matter.

LaQuita B. Goodwin
Compliance Specialist
Legal Department
ProAssurance Professional Liability Group
Medical Assurance/ProNational/NCRIC/PIC WISCONSIN
Woodbrook Casualty/Red Mountain Casualty
Birmingham, Alabama
(205) 877-4426 or (800) 282-6242, ext. 4426 Fax (205) 414-2887

Neuman, Gayle

From: Goodwin, LaQuita [LGoodwin@proassurance.com]
Sent: Wednesday, May 21, 2008 3:01 PM
To: Neuman, Gayle
Subject: RE: Dental Filing #IL-DPL-0208
Attachments: Final copy of PIC manual.pdf; DPL Classifications.PDF; Excess Factors Page.PDF; Rating Factors Page.PDF

Ms. Neuman,

Thank you for speaking with me today regarding PIC Wisconsin's 1997 dental manual.

Please note that PIC Wisconsin's Filing # PL IL2004R06, effective December 1, 2004, replaced the 1997 dental manual. Please refer to Pamela Otterback's cover letter dated January 12, 2005 in your department's copy. Response number 1 states that the Professional Liability Rule and Rating manual applies to claims-made and occurrence professional liability policies for all health care providers. I have, however, added the page numbering to the classifications and rate pages.

It is our intention to adopt ProNational's format upon the next rate filing, which should be within the next year.

I believe you will find my response to your concerns sufficient. If you have any further questions or concerns, please contact me.

Thank you for your immediate attention to this matter.

LaQuita B. Goodwin
Compliance Specialist
Legal Department
ProAssurance Professional Liability Group
Medical Assurance/ProNational/NCRIC/PIC WISCONSIN
Woodbrook Casualty/Red Mountain Casualty
Birmingham, Alabama
(205) 877-4426 or (800) 282-6242, ext. 4426 Fax (205) 414-2887

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, May 05, 2008 1:26 PM
To: Goodwin, LaQuita
Subject: Dental Filing #IL-DPL-0208

Ms. Goodwin,

We are in receipt of your e-mail response dated May 1, 2008.

We are fine with the page numbering you have - and appreciate the explanation given. However, on the Illinois rates pages, there is no page numbering. It helps our assistants when replacing pages in the manual.

The attachments on your May 1, 2008 e-mail did not include the DENTAL manual pages, rather the healthcare providers pages. Therefore, please submit the pages for the dental section.

Your prompt attention is appreciated.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

Neuman, Gayle

From: Goodwin, LaQuita [LGoodwin@proassurance.com]
Sent: Wednesday, August 12, 2009 2:37 PM
To: Neuman, Gayle
Subject: RE: PIC Wisc. Filings

Hi Gayle.

Thank you for your email and voice message. Yes, you have the correct email address.

I checked my records and don't see that you ever asked us this question on these two filings. I was waiting on a response to your question and just received it today. ISO is the stat agent we use for all ProAssurance Companies.

I didn't realize until yesterday, after speaking with Murray, that we haven't received "official" approval or acknowledgement from your department on these filings. Is there something that you can send for our records?

Thanks.

LaQuita

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, August 11, 2009 3:25 PM
To: Goodwin, LaQuita
Subject: PIC Wisc. Filings

Ms. Goodwin,

I apologize for the extended delay in the handling of the pending medical malpractice filings. On filings #PIC-MPL-1207 and #IL-DPL-0208, I requested information about if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used? Unfortunately, I cannot find where an answer was provided in response.

Please forward this information as soon as possible. Thank you for your cooperation.

Gayle Neuman
Illinois Department of Insurance
Property & Casualty Compliance
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Department's website at www.insurance.illinois.gov.

www.proassurance.com

Neuman, Gayle

From: Neuman, Gayle
Sent: Friday, August 14, 2009 9:54 AM
To: 'Goodwin, LaQuita'
Subject: RE: Dental Filing #IL-DPL-0208

Ms. Goodwin,

I don't previously have anything in file saying the pages specifically designated as "dental" only should be withdrawn. However, you can instruct me to do exactly that at this time – it will have the same effective date as this filing. And I would also request one pdf providing a copy of every page in the manual (rates and rules) that applies to physicians, surgeons, dentists and allied health professionals. Then we can hopefully move this filing on. Thank you for your continued cooperation.

Gayle Neuman
Department of Insurance

From: Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]
Sent: Friday, August 14, 2009 9:17 AM
To: Neuman, Gayle
Subject: RE: Dental Filing #IL-DPL-0208

Ms. Neuman,

If I recall correctly, this issue was addressed verbally and by email. For your convenience, I'm attaching the last email I forwarded to you regarding this issue along with a copy of the 1/12/05 letter from Pam Otterback referenced in it. The letter states that the Healthcare Providers Manual is used for all healthcare providers, which in our case, means physicians, surgeons, dentists and allied health professionals.

I believe this response should be sufficient. Let me know if you have any other questions or concerns.

LaQuita B. Goodwin

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, August 14, 2009 8:20 AM
To: Goodwin, LaQuita
Subject: Dental Filing #IL-DPL-0208

Ms. Goodwin,

I currently have three pending PIC Wisc. Filings from 2008. I apologize for the extended delay in the review.

This filing in particular was very confusing. This is a dental filing however in your May 21, 2008 filing you provided pages titled "Healthcare Providers" when that is not the issue of this filing. Therefore, again, please provide a copy of all pages in the manual for the dental program ONLY. Your prompt attention is appreciated so that I may finally conclude my review of this filing.

Gayle Neuman

Illinois Department of Insurance
Property & Casualty Compliance
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Department's website at www.insurance.illinois.gov.

www.proassurance.com

Med 1/14/05

January 12, 2005

Gayle Neuman
Property & Casualty Compliance Unit
Illinois Department of Financial & Professional Regulation, Division of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: Filing #PL IL 2004R06 - Professional Liability Rule and Rating Manual

Dear Gayle,

Please accept this response to your email of December 15, 2004 regarding the above referenced filing. I will respond to your email in the order of your questions.

1. The Professional Liability Rule and Rating manual applies to claims-made and occurrence professional liability policies for all health care providers. It does not apply to Ambulance Service, Home Health Care Agencies, Hospitals or Nursing Homes.

2. The reference to the effective date of each page of the manual has been updated on the Illinois Program Page, attached. In general, the Program Page has been reformatted in an effort to clarify modifications to the preceding pages of the manual.

3. General Rules, V. Limits of Liability B. Deductibles: An underwriter will apply a mandatory deductible in response to loss frequency.

4. General Rules, VI. Policy Periods: The Illinois Programs Page has been amended to include reference to the statute indicated.

5. General Rules, XII Extended Reporting Coverage: Please refer to the Illinois Program Page, which clarifies that this coverage will be offered.

6. General Rules, XII Extended Reporting Coverage: Please refer to the Illinois Programs Page, F. Premiums, which clarifies how the ERC is priced.

7. General Rules, XIII, Partnership, Professional Corporation or Professional Association Coverage: Our intent is that all health care providers within a group must be insured with PIC WISCONSIN in order to be eligible for Corporate Professional Liability Coverage. Exceptions to this all-or-none rule for corporate coverage are granted in instances where PIC WISCONSIN determines a member(s) is unacceptable for coverage or would lose the benefit of free Extended Reporting Coverage from their current carrier if they were to switch carriers at this time.

8. General Rules, XVII, Reunderwriting Rating Mechanisms: As requested, enclosed is a certified statement of non-discrimination.

9. General Rules, XVII, A. Surcharge and/or Coverage Exclusion: As requested, enclosed is a certified statement of non-discrimination.

10. Manual Page G, Surcharge and/or Procedures Exclusion Criteria: The procedures that may be excluded will vary based on factors such as claim frequency, procedure training and experience, or an MEB ruling. An example of a current procedure that may be excluded is Bariatric Surgery. As requested, enclosed is a certified statement of non-discrimination.

11. Illinois State Program Page W (previous version), Schedule Credit/Debit Programs: Revised Page X.2 and 3 lists the debit/credit programs available and the corresponding amounts.

12. Illinois Stage Program Page X (previous version), Extended Reporting Coverage: This section has been re-worked to remove any ambiguity about the fact that Extended Reporting Coverage will be offered in all instances.

13. Illinois State Program Page X.3 (previous version), Voluntary Deductibles, Full Limits Deductible and impact on premium and the deductible credits listed on page X.1.: The deductible credits on page X.1. do not apply to a Full Limits Deductible Policy. The policyholder under a Full Limits Deductible policy assumes responsibility for all loss costs, so that the premium charged for a Full Limits Deductible policy is to cover only the administration and claims handling of the account.

Thank you for your consideration of these amendments and explanations. Please let me know if you need further clarification.

Sincerely,

Pamela Otterback
Product and Compliance Manager

Enclosure: Rules and Rating Manual Illinois Program Page
Certificate of Non-Discrimination

Neuman, Gayle

From: Goodwin, LaQuita [LGoodwin@proassurance.com]
Sent: Friday, August 21, 2009 10:09 AM
To: Neuman, Gayle
Subject: RE: Dental Filing #IL-DPL-0208
Attachments: PRA Wisconsin dental manual eff 2-15-08.pdf

Ms. Neuman,

When I made this filing on 12/21/07 for Physicians Insurance Company of Wisconsin (now known as ProAssurance Wisconsin Insurance Company), it was indeed for Healthcare Providers, which consisted of physicians, surgeons, dentists and allied health professionals. However, I realized that I later submitted a filing on 11/11/08, Filing Number IL0109, for ProNational Insurance Company (now known ProAssurance Casualty Company) removing all dental references and indicated that dental coverage will be written through Physicians Insurance Company of Wisconsin, whose rates, rules and forms were on file with your department. With that being said, the attached manual is indeed to be used for dentists only.

Please note that dental coverage will be written through ProAssurance Wisconsin Insurance Company and physician business will be written through ProAssurance Casualty Company.

I apologize for the confusion and hope that you find this response sufficient. If you have any other questions or concerns, please let me know.

LaQuita B. Goodwin

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, August 14, 2009 9:54 AM
To: Goodwin, LaQuita
Subject: RE: Dental Filing #IL-DPL-0208

Ms. Goodwin,

I don't previously have anything in file saying the pages specifically designated as "dental" only should be withdrawn. However, you can instruct me to do exactly that at this time – it will have the same effective date as this filing. And I would also request one pdf providing a copy of every page in the manual (rates and rules) that applies to physicians, surgeons, dentists and allied health professionals. Then we can hopefully move this filing on. Thank you for your continued cooperation.

Gayle Neuman
Department of Insurance

From: Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]
Sent: Friday, August 14, 2009 9:17 AM
To: Neuman, Gayle
Subject: RE: Dental Filing #IL-DPL-0208

Ms. Neuman,

If I recall correctly, this issue was addressed verbally and by email. For your convenience, I'm attaching the last email I forwarded to you regarding this issue along with a copy of the 1/12/05 letter from Pam Otterback referenced in it. The letter states that the Healthcare Providers Manual is used for all healthcare providers, which in our case, means physicians, surgeons, dentists and allied health professionals.

I believe this response should be sufficient. Let me know if you have any other questions or concerns.

LaQuita B. Goodwin

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Friday, August 14, 2009 8:20 AM
To: Goodwin, LaQuita
Subject: Dental Filing #IL-DPL-0208

Ms. Goodwin,

I currently have three pending PIC Wisc. Filings from 2008. I apologize for the extended delay in the review.

This filing in particular was very confusing. This is a dental filing however in your May 21, 2008 filing you provided pages titled "Healthcare Providers" when that is not the issue of this filing. Therefore, again, please provide a copy of all pages in the manual for the dental program ONLY. Your prompt attention is appreciated so that I may finally conclude my review of this filing.

Gayle Neuman
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Property & Casualty Compliance
(217) 524-6497

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Neuman, Gayle

From: Goodwin, LaQuita [LGoodwin@proassurance.com]
Sent: Monday, December 21, 2009 9:36 AM
To: Neuman, Gayle
Subject: RE: Dental Filing #IL-DPL-0208
Attachments: PRA Wisconsin dental manual eff 2-15-08.pdf

Ms. Neuman,

Thank you for speaking with me today. I apologize for the confusion and hope that we can resolve these issues today.

Please use the attached manual for the dentist program only. We are aware that certain rules does not apply to dentists and we are working on updating all ProAssurance Wisconsin (formerly PIC Wisconsin) filings at this time. Because we now write physicians/surgeons through ProAssurance Casualty Company (formerly ProNational), the physicians/surgeons section will no longer apply. The hospital section, however, should remain on file for ProAssurance Wisconsin.

If you have any other questions or concerns, please do not hesitate to contact me.

LaQuita B. Goodwin

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, December 21, 2009 9:17 AM
To: Goodwin, LaQuita
Subject: FW: Dental Filing #IL-DPL-0208

From: Neuman, Gayle
Sent: Wednesday, September 09, 2009 1:27 PM
To: 'Goodwin, LaQuita'
Subject: RE: Dental Filing #IL-DPL-0208

Ms. Goodwin,

Hopefully, I have just one more question. I may have asked it before. The manual has a dentist section and a separate physicians/surgeons section – so do you wish to do away with both sections and replace it with the section attached to your e-mail today? That will still leave a separate section in this manual on hospitals. Please clarify at your earliest convenience.

Gayle Neuman
Department of Insurance

From: Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]
Sent: Wednesday, September 09, 2009 9:27 AM
To: Neuman, Gayle

Subject: RE: Dental Filing #IL-DPL-0208

Ms. Neuman,

I realized that I haven't responded to this email and I apologize for inadvertently overlooking it.

I do understand your concern that references throughout the manual are not only for dentists, but other classes as well. The decision to move physicians and other classes to ProAssurance Casualty was made after this filing and we haven't gotten around to updating the manual yet. It is our intention, however, to do that just that.

Pursuant to your request, I have updated the title on page 1 to reference Dental Professional Liability. Hopefully, this will address your final concern. If not, let me know.

Thank you.

LaQuita B. Goodwin

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, August 24, 2009 2:09 PM
To: Goodwin, LaQuita
Subject: RE: Dental Filing #IL-DPL-0208

Ms. Goodwin,

I briefly reviewed the manual pages attached to your August 21, 2009 e-mail (below). The first pages is labeled as "Healthcare Providers" which you have previously defined as all classes – certainly not just dentists. Page 4 references surgeries that don't exactly pertain to dentist. On page 10, the examples for determining extended reporting periods (although just an example) references gynecology – not dentist. Page A and B references certified nurse midwives, etc. These are all just examples of references in the manual that is supposed to be for dentists only. It should be safe to say the title on page 1 should at least be changed.

Gayle Neuman
Department of Insurance

From: Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]
Sent: Friday, August 21, 2009 10:09 AM
To: Neuman, Gayle
Subject: RE: Dental Filing #IL-DPL-0208

Ms. Neuman,

When I made this filing on 12/21/07 for Physicians Insurance Company of Wisconsin (now known as ProAssurance Wisconsin Insurance Company), it was indeed for Healthcare Providers, which consisted of physicians, surgeons, dentists and allied health professionals. However, I realized that I later submitted a filing on 11/11/08, Filing Number IL0109, for ProNational Insurance Company (now known ProAssurance Casualty Company) removing all dental references and indicated that dental coverage will be written through Physicians Insurance Company of Wisconsin, whose rates, rules and forms were on file with your department. With that being said, the attached manual is indeed to be used for dentists only.

Please note that dental coverage will be written through ProAssurance Wisconsin Insurance Company and physician business will be written through ProAssurance Casualty Company.

I apologize for the confusion and hope that you find this response sufficient. If you have any other questions or concerns, please let me know.

LaQuita B. Goodwin

www.proassurance.com

XIII. *Partnership, Professional Corporation or Professional Association Coverage*

Partnerships, professional corporations (including solo corporations), or professional associations may receive a primary insurance policy at the option of the insured (unless required by law) at a charge that is based on the net premium charge for the individual healthcare providers of the entity, provided that the Company insures all principals as individuals. (See Manual Page A) Exceptions to this "all-or-none" rule may be made at the Company's discretion. The minimum premium charge for this coverage is $100. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association.

XIV. *Employee Professional Liability Coverage*

A. Definitions: Employees (other than a physician or resident) are covered under an insured's policy if they are employed by the named insured and are acting within the scope of their duties as such. Refer to the policy for the definition of employees.

B. Limits of Liability: Such employees share in the limits of liability with their employer. They do not receive their own individual limits of liability. In some cases, individual limits of liability are available for employees at an additional charge. See Rate Pages.

All other manual rates are applicable.

XV. *Prior Acts Coverage -- Applies To Claims-Made Policies Only*

For insureds who have been covered under a claims-made policy with another insurance carrier, we can offer Prior Acts Coverage, subject to underwriting approval. Prior Acts Coverage will recognize the insured's retroactive date under the previous policy. However, special rules for claims apply to Prior Acts Coverage, as specified in the most current policy form.

Prior Acts Coverage is limited to activities in those states where PIC Wisconsin is licensed to write professional liability coverage, or where we are legally allowed to and have agreed to do so. If we are unable to provide Prior Acts Coverage due to licensing or underwriting restrictions, the insured must obtain Extended Reporting Coverage for that exposure from their previous carrier. Rating for Prior Acts Coverage is based on the same criteria as the insured's base coverage, including retroactive date, specialty classification and other applicable factors as described throughout this Rule and Rating Manual.

XVI. *Experience Rating Plan*

The experience rating plan provides an adjustment to a policyholder's current premium, based on the loss history of that particular policyholder.

The experience modification factor is applied to the rate developed from the rates and rules in our standard filing. The experience modification factor is derived from a formula-based credibility factor. The credibility factor is the result of the expected claim count of the policyholder, as developed from past claims history.

Physicians Insurance Company of Wisconsin
Dental Professional Liability Rates

Illinois
Effective 2/15/2008

Rating Factors

A. Base Rate (Class 1, Territory 2, Mature Claims-Made, $100K/ $300K): **$592**

B. Classification Relativities:

Class	Relativity
1	1.000
2	2.000
3	6.000

C. Territorial Relativities

	Relativity
Territory 1	1.47
Territory 2	1.00

D. Claims-Made Maturity Factors

Maturity	All Classes
1st Year	0.330
2nd Year	0.610
3rd Year	0.800
4th Year	0.900
5th Year	1.000
Occurrence Rate	1.170

E. Increased Limits Factors

Limits in 000's	Class 1 and 2
100/300	1.0000
200/600	1.1000
500/1500	1.3300
1000/3000	1.5500

F. Extended Reporting Endorsement Factors

Maturity	All Classes
12 Mos.	0.676
24 Mos.	1.061
36 Mos.	1.255
48 Mos.	1.350
60 Mos.	1.439

G. Rating Algorithms

Claims-Made Rate = Base Rate x Class Relativity x Territorial Relativity x Clms-Made Maturity Factor x Increased Limit Factor

Occurrence Rate = Base Rate x Class Relativity x Territorial Relativity x Occurrence Factor x Increased Limit Factor

Reporting Endorsement Rate = Base Rate x Class Relativity xTerritorial Relativity x Tail Factor x Increased Limit Factor

	$1M/$3M Charge			$500K/$1.5M			$200K/$600K		
	PRA	IL Prop.		PRA	IL Prop.		PRA	IL Prop.	
# of Insureds	Std.	Phys	Dental	Std.	Phys	Dental	Std.	Phys	Dental
1	N/A	N/A	5.0%	N/A	N/A	N/A	N/A	N/A	N/A
2 - 5	15.0%	N/A	5.0%	18.0%	N/A	18.0%	23.0%	N/A	23.0%
6 - 9	12.0%	N/A	5.0%	17.0%	N/A	17.0%	21.0%	N/A	21.0%
10 - 19	9.0%	N/A	5.0%	13.0%	N/A	13.0%	17.0%	N/A	17.0%
20 - 49	7.0%	N/A	5.0%	9.0%	N/A	9.0%	13.0%	N/A	13.0%
50 or more	5.0%	N/A	5.0%	7.5%	N/A	7.5%	10.0%	N/A	10.0%

• ***Partnership - Corporation - Professional Association Extended Reporting Endorsement Coverage***

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. For the entity to be eligible for the separate limit extended reporting endorsement, all physician members insured on the policy must exercise their right to purchase an individual extended reporting endorsement. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member physician's net individual reporting endorsement premium, based on the number of insureds and the table in the Paragraph above.

• ***Quarterly Installment Options***

1. Quarterly Installment Option One
   a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
   b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

2. Quarterly Installment Option Two – (35/25/25/15)
   a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
   b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

Neuman, Gayle

From: Goodwin, LaQuita [LGoodwin@proassurance.com]
Sent: Tuesday, December 22, 2009 3:03 PM
To: Neuman, Gayle
Subject: RE: Filing #IL-DPL-0208
Attachments: IL FormRF-3.pdf; FW: Healthcare Providers - Rate/Rule Filing #PIC-MPL-1207

The correct amount, as indicated on the original RF3, is a 0.03% decrease, not 0.3%.

As for your last paragraph, these issues were addressed in another filing, filing number PIC-MPL-1207.

Please let me know if you have any other questions.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 22, 2009 1:29 PM
To: Goodwin, LaQuita
Subject: RE: Filing #IL-DPL-0208

The RF-3 Summary Sheet is suppose to provide information on changes in rate level based on the company's premium volume rating system and distribution of business. Therefore, the .03% decrease for the entire med mal program is appropriate. Previously, you have indicated 0.3 and 0.03 – please confirm which is appropriate. Is the annual premium volume on the RF-3 for the entire med mal program too?

Does your experience rating plan, scheduled rating plan or surcharge/procedure exclusion criteria have a maximum limit? In regard to the surcharge criteria, does this apply to a physician who has diabetes or epilepsy?

Gayle Neuman
Department of Insurance

From: Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]
Sent: Tuesday, December 22, 2009 10:13 AM
To: Neuman, Gayle
Subject: RE: Filing #IL-DPL-0208

Yes, dental only. Please find a revised RF3 with the dental impact only.

Please let me know if you need anything else.

LaQuita

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 22, 2009 9:57 AM
To: Goodwin, LaQuita
Subject: RE: Filing #IL-DPL-0208

This is not my decision to make. However, this was suppose to be a filing for dental only, right?

From: Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]

Sent: Tuesday, December 22, 2009 9:19 AM
To: Neuman, Gayle
Subject: RE: Filing #IL-DPL-0208

Gayle,

I spoke with the actuary who completed this form and she wanted me to get clarification. The 0.2% decrease listed was for the dental filing. The 0.3% decrease, which she listed on the RF3, was the impact on the entire med mal program, as indicated on the form. Was the RF3 suppose to be for the dental filing only, or the entire med mal program? Please let me know and we'll correct it based on your response. Thanks.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 22, 2009 8:30 AM
To: Goodwin, LaQuita
Subject: RE: Filing #IL-DPL-0208

Then, I will need a corrected RF-3 form as soon as possible.

From: Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]
Sent: Tuesday, December 22, 2009 8:29 AM
To: Neuman, Gayle
Subject: RE: Filing #IL-DPL-0208

No, the RF-3 was incorrect. It should have been a 0.2% decrease.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 22, 2009 8:28 AM
To: Goodwin, LaQuita
Subject: RE: Filing #IL-DPL-0208

Ms. Goodwin,

So, please clarify – does the RF-3 indicate the correct amount?

Gayle Neuman
Department of Insurance

From: Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]
Sent: Tuesday, December 22, 2009 8:15 AM
To: Neuman, Gayle
Subject: RE: Filing #IL-DPL-0208

You are correct that the RF3 indicated a 0.3% decrease. It was actually a 0.2% decrease. I apologize for this oversight.

Please let me know if you have any other questions.

Thanks.

LaQuita

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 22, 2009 8:03 AM
To: Goodwin, LaQuita
Subject: Filing #IL-DPL-0208

Ms. Goodwin,

Hopefully, this is my last question. When the filing was submitted, documents indicated you were filing a 2% or 20% decrease to rates. The RF-3 provided however indicated a 3% decrease. Please clarify the amount of rate change with this filing. I would appreciate an answer as soon as possible.

Gayle Neuman
Illinois Department of Insurance
Property & Casualty Compliance
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Department's website at www.insurance.illinois.gov.

Neuman, Gayle

From: Goodwin, LaQuita [LGoodwin@proassurance.com]
Sent: Tuesday, December 22, 2009 3:42 PM
To: Neuman, Gayle
Subject: RE: Filing #IL-DPL-0208

Gayle,

I need to clarify one of your questions.

The maximum deviation available under the schedule credit/debit program is 75% for physicians and dentists. There is no max on the experience rating plan or the surcharge/procedure exclusion criteria. The earlier filing, however, did address surcharging the physician that has diabetes or epilepsy. It's not Company practice to ask if a physician has diabetes or epilepsy, so we would not surcharge someone if they do not have these diseases.

One additional note. I will be out of the office the rest of the week. Because I want to address these matters in a timely manner, I will be available on my cell phone at 205-401-4938. You may also contact Kate Richardson (krichardson@proassurance.com and 205-877-4780) who will be in the office tomorrow.

Thank you.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 22, 2009 1:29 PM
To: Goodwin, LaQuita
Subject: RE: Filing #IL-DPL-0208

The RF-3 Summary Sheet is suppose to provide information on changes in rate level based on the company's premium volume rating system and distribution of business. Therefore, the .03% decrease for the entire med mal program is appropriate. Previously, you have indicated 0.3 and 0.03 – please confirm which is appropriate. Is the annual premium volume on the RF-3 for the entire med mal program too?

Does your experience rating plan, scheduled rating plan or surcharge/procedure exclusion criteria have a maximum limit? In regard to the surcharge criteria, does this apply to a physician who has diabetes or epilepsy?

Gayle Neuman
Department of Insurance

From: Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]
Sent: Tuesday, December 22, 2009 10:13 AM
To: Neuman, Gayle
Subject: RE: Filing #IL-DPL-0208

Yes, dental only. Please find a revised RF3 with the dental impact only.

Please let me know if you need anything else.

LaQuita

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 22, 2009 9:57 AM
To: Goodwin, LaQuita
Subject: RE: Filing #IL-DPL-0208

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To: Neuman, Gayle
Subject: RE: Filing #IL-DPL-0208

Gayle,

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From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
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Sent: Tuesday, December 22, 2009 8:29 AM
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Subject: RE: Filing #IL-DPL-0208

No, the RF-3 was incorrect. It should have been a 0.2% decrease.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 22, 2009 8:28 AM
To: Goodwin, LaQuita
Subject: RE: Filing #IL-DPL-0208

Ms. Goodwin,

So, please clarify – does the RF-3 indicate the correct amount?

Gayle Neuman
Department of Insurance

From: Goodwin, LaQuita [mailto:LGoodwin@proassurance.com]

Sent: Tuesday, December 22, 2009 8:15 AM
To: Neuman, Gayle
Subject: RE: Filing #IL-DPL-0208

You are correct that the RF3 indicated a 0.3% decrease. It was actually a 0.2% decrease. I apologize for this oversight.

Please let me know if you have any other questions.

Thanks.

LaQuita

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Tuesday, December 22, 2009 8:03 AM
To: Goodwin, LaQuita
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Ms. Goodwin,

Hopefully, this is my last question. When the filing was submitted, documents indicated you were filing a 2% or 20% decrease to rates. The RF-3 provided however indicated a 3% decrease. Please clarify the amount of rate change with this filing. I would appreciate an answer as soon as possible.

Gayle Neuman
Illinois Department of Insurance
Property & Casualty Compliance
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Department's website at www.insurance.illinois.gov.

May 21, 2008

Ms. Gayle Neuman
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767

RE: Physicians Insurance Company of Wisconsin, Inc. - NAIC # 23400
A ProAssurance Company
Line of Business – Medical Malpractice – Class 2 Clause (c)
Medical Professional Liability
Company Filing #PIC-MPL-1207

Dear Ms. Neuman:

Please find the following responses to your email dated May 5, 2008:

Item 1
It is our position that the extended reporting endorsement cannot be cancelled for non-payment of premium. In purchasing the extended reporting endorsement, if the insured's payment is dishonored, pursuant to 215 ILCS 5/143.13 the coverage (i.e. the extended reporting endorsement) is void and not subject to cancellation. Therefore, the second paragraph of section XII. C. should be deleted or it can be changed on Manual Page W or X.

Answer 1
We acknowledge that extended reporting endorsements cannot be cancelled for nonpayment of premium. I have amended the second paragraph of Section XII. C. You can locate this correction on Illinois Program Page W.

Item 2
2. Extended reporting period (tail coverage) premium must be priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium. The form must list the factor(s) to be used to figure the premium, which of the three premiums the factor will be applied to, and any credits, discounts, etc. that will be added or removed when determining the final premium. The company must inform the insured of the extended reporting period premium at the time the last policy is purchased. The company may not wait until the insured requests purchase of the extended reporting period coverage to tell the insured what the premium will be or how the premium will be calculated. Therefore, please correct the paragraphs of section XII. F. or it can be changed on Manual Page W or X.

Answer 2
On Manual Page X, Item XII. F. has been further amended to comply with the extended reporting period (tail coverage) requirement. The Illinois State Amendatory Endorsement has also been amended and will inform the insured of the extended reporting period premium at policy issuance. Please see attached.

Item 3
3. On Manual Page G, Risk Characteristic #8 indicates "illness or physical disability that impairs, or could impair, the healthcare provider's ability to practice his/her specialty". Are you surcharging a doctor with diabetes or epilepsy the same as you are surcharging a doctor with alcoholism? Please explain.

Answer 3
Upon further review, we have revised this risk characteristic for clarity. Please refer to the revised Manual Page G. We have never surcharged a physician for a medical condition, other than alcoholism or drug abuse. It is not Company practice to ask if a physician has diabetes or epilepsy, so we would not surcharge someone if they do have these diseases.

Item 4
4. On Manual Page M, the maximum modification based on A and B above is +/- 25%.

Answer 4
I have amended the maximum debit/credit to reflect +/-25%.

Item 5
5. On Manual Page X.2., for the $1,000 deductible, how do you determine if the insured gets a 1.8% credit or a 2.2% credit? Please explain this range of credit for the entire chart.

Answer 5
Revisions have been made to this entire chart by designating a specific amount instead of a range. Due to the installment plans being added to the manual, please refer to Manual Page X.2.

Item 6

6. Not all changes were reported as required. As previously stated, any changes not highlighted will not be deemed filed. On page 7 under XVI. Experience Rating Plan, the wording "(NOT APPLICABLE IN NEVADA)" was removed. Please address.

Answer 6

This language was unnecessary as the Nevada Program pages contained an Experience Rating Section which overrides the general section for that state. However, we cannot

find documentation as to when the words were omitted. Since the words conflict with the state program section, I am requesting that you accept the page with these words omitted.

Item 7
7. Not all changes were reported as required. As previously stated, any changes not highlighted will not be deemed filed. On Manual Pages G and H, numbering was changed (actually it was corrected) but the change was not disclosed.

Answer 7
I cannot locate when or how this numbering was corrected; however, I am requesting that you accept the page with the correct numbering.

I have carefully reviewed the entire manual that was filed with your department that was effective December 1, 2004 and compared it to the marked copy of the manual and the final manual that I submitted to your department to be effective December 15, 2007. Other than what is in the marked manual and the two corrections listed in Items 6 and 7 above, there are no other changes to disclose. I am enclosing an copy of the manual, with all corrections, for your approval.

I believe you will find everything in order. If you have any questions regarding this filing, please contact me at (800) 282-6242, ext. 4426, or e-mail me at lgoodwin@proassurance.com.

Sincerely,

LaQuita B. Goodwin

LaQuita B. Goodwin
Compliance Specialist

Enclosures

Section 754.EXHIBIT A Summary Sheet (Form RF-3)

FORM (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 2/15/2008.

	(1) Coverage	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
1.	Automobile Liability Private Passenger		
	Commercial		
2	Automobile Physical Damag Private Passenger		
	Commercial		
3.	Liability Other Than Auto		
4.	Burglary and Theft		
5.	Glass		
6.	Fidelity		
7.	Surety		
8.	Boiler and Machinery		
9.	Fire		
10.	Extended Coverage		
11.	Inland Marine		
12.	Homeowners		
13.	Commercial Multi-Peril		
14.	Crop Hail		
15.	Other Medical Malpractice Life of Insurance	6,073,810	-0.03%

Does filing only apply to certain territory (territories) or certain Classes? If so, specify: No

Brief description of filing. (If filing follows rates of an advisory Organization, specify organization): Revised dentists increased limit and excess factors.

*Adjusted to reflect all prior rate changes.
**Change in Company's premium level which will result from application of new rates.

Physicians Insurance Company of Wisconsin, Inc.
Name of Company

LaQuita B. Goodwin - Compliance Specialist
Official – Title

Physicians Insurance Company of Wisconsin

Dental Professional Liability
Filing Memorandum

Illinois

This memorandum and the attached exhibits summarize a revision to dental professional liability rates for Physicians Insurance Company of Wisconsin (PICW), in the state of Illinois. The overall impact of this rate filing is -0.2%. The proposed effective date for this change is 2/15/2008.

The filing includes revisions to increased limit factors (ILF) above $1M/$3M based on our current, negotiated reinsurance contract.

Effective in August of 2006, PICW merged with ProAssurance Corporation. We are in the process of merging the computer systems for the two companies. As part of the conversion of the PICW processing into the ProAssurance system, limits above $1M/$3M will now be shown on our policies and forms as an excess layer above primary limits of $1M/$3M. Limits that are not available as a primary and excess layer will no longer be offered.

Exhibit 1 - Dentists Excess Factors
Shows the calculation of the rate impact for the dentists excess factor change. Policies with a $3M/$3M or $5M/$5M primary limit will no longer be available. Policyholders with these limits will be contacted about this revision upon their next renewal.

Exhibit 2 - Dentists Rating & Excess Factors
Shows the revised Dentists rating and excess factors. The Increased Limits Factors on Sheet 1 are revised and the Excess Limits Premium Factors on Sheet 2 are added. All other rates and factors remained the same.

Physicians Insurance Company of Wisconsin
Dental Professional Liability

Dentists Excess Factors

Classes 1 & 2

Limits in 000's	Current Factor at $100K/$300K	Proposed Factor at $100K/$300K	Current Factor at $1M/$3M	Proposed Factor at $1M/$3M
100/300	1.0000	1.0000	0.6452	0.6452
200/600	1.1000	1.1000	0.7097	0.7097
500/1,500	1.3300	1.3300	0.8581	0.8581
1,000/3,000	1.5500	1.5500	1.0000	1.0000
3,000/3,000	1.7000	n/a	1.0968	n/a
5,000/5,000	1.8500	n/a	1.1935	n/a

Class 3

Limits in 000's	Current Factor at $100K/$300K	Proposed Factor at $100K/$300K	Current Factor at $1M/$3M	Proposed Factor at $1M/$3M
100/300	1.0000	1.0000	0.6452	0.6452
200/600	1.1000	1.1000	0.7097	0.7097
500/1,500	1.3300	1.3300	0.8581	0.8581
1,000/3,000	1.5500	1.5500	1.0000	1.0000
3,000/3,000	1.8500	n/a	1.1935	n/a
5,000/5,000	2.0000	n/a	1.2903	n/a

Layer	Percent Premium	Average Class 1/2 & 3 Current Factor at $1M/$3M	Proposed Factor	Proposed Percent Change
$1M xs $1M	0.00%	n/a	4.80%	0.00%
$1M xs $2M	5.20%	14.52%	9.60%	-4.30%
$1M xs $3M	0.00%	n/a	14.50%	0.00%
$1M xs $4M	0.00%	19.35%	19.35%	0.00%
$1M xs $5M	0.00%	n/a	22.25%	0.00%
Primary	94.80%			0.00%
Total				-0.20%

Note: Data for the $3,000/$3,000 limit is included in $1M xs $2M layer.
Data for the $5,000/$5,000 limit is included in $1M xs $4M layer.

Physicians Insurance Company of Wisconsin
Dental Professional Liability

Dentists Rating & Excess Factors

Rating Factors

A. Base Rate (Class 1, Territory 2, Mature Claims-Made, $100K/ $300K): $592

B. Classification Relativities:

Class	Relativity
1	1.000
2	2.000
3	6.000

C. Territorial Relativities

Territory	Relativity
1	1.47
2	1.00

D. Claims-Made Maturity Factors

Maturity	All Classes
1st Year	0.330
2nd Year	0.610
3rd Year	0.800
4th Year	0.900
5th Year	1.000
Occurrence Rate	1.170

E. Increased Limits Factors

Limits in 000's	All Classes
100/300	1.0000
200/600	1.1000
500/1,500	1.3300
1,000/3,000	1.5500

F. Extended Reporting Endorsement Factors

Maturity	All Classes
12 Mos.	0.676
24 Mos.	1.061
36 Mos.	1.255
48 Mos.	1.350
60 Mos.	1.439

G. Rating Algorithms

Claims-Made Rate = Base Rate x Class Relativity x Territorial Relativity x Claims-Made Maturity Factor x Increased Limit Factor
Occurrence Rate = Base Rate x Class Relativity x Territorial Relativity x Occurrence Factor x Increased Limit Factor
Reporting Endorsement Rate = Base Rate x Class Relativity x Territorial Relativity x Tail Factor x Increased Limit Factor

Physicians Insurance Company of Wisconsin
Dental Professional Liability

Dentists Rating & Excess Factors

Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate for limits above $1M/$3M primary.

Excess Limit	Factor
$1M	0.0480
$2M	0.0960
$3M	0.1450
$4M	0.1935
$5M	0.2225

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.

General Rule and Rating Manual

Dental Professional Liability

General Rules

I. *General Instructions*

This manual contains the rules, classifications and rates governing the underwriting of healthcare providers' professional liability claims-made and occurrence insurance. The rules, classifications and rates in this manual become effective as of the date indicated upon each page.

Coverage that is provided on or after the effective dates of any changes in this manual (either by endorsement of outstanding policies or by the issuance of separate policies) will be written on the basis of the rates and rules in effect at the time the policy is effective.

The following requirements must be observed in the preparation of policies for insurance covered by this manual:

- Appropriate wording identifying the classifications applicable for each risk will be specified on the policy Declarations or Coverage Summary, including the appropriate code number.
- Any language in classification phraseology or footnotes affecting the scope of the classification applicable or assigned to operations to be insured will be incorporated on the Declarations or Coverage Summary of the policy.
- For each classification, the proper premium will be calculated either as actual or as an adequate estimate subject to audit, dependent on the case.

II. *Scope of Coverage*

Each professional liability policy provides the details of the coverage and exclusions that are incorporated into the terms of the policy.

III. *Persons Insured*

The persons or entities insured under the policy are specified on the Declarations or Coverage Summary of each professional liability policy, or are described in the language of the policy form.

IV. *Definitions*

The definitions of the key terms used in the policy are provided in an introductory section of the professional liability policy.

V. *Limits of Liability*

A. Statutory Requirements: The limits of liability for some healthcare providers (as defined by the appropriate state statute) are statutorily specified. Accordingly, all primary insurance coverage for these healthcare providers must provide the minimum level of limits, as specified in the applicable statutes. In other states where limits of liability are *not* statutorily specified, refer to filed rate pages for per professional heathcare incident and annual aggregate limits of liability.

For individual professional liability, the limits of liability apply separately to each individual insured. For entity, partnership, association or corporation professional liability coverage, the inclusion of more than one insured does not increase the limits of liability. Employees (as defined in the policy or endorsements to the policy) of individuals, entities, partnerships, associations or corporations share in their employer's limit of liability, unless separate limits of liability are purchased, if available.

B. Deductibles: Deductibles are a method of coverage under which the insured agrees to reimburse us for damages and/or expenses we pay on the insured's behalf. The amount of reimbursement will be the amount of the deductible or the damages and/or expenses paid on the insured's behalf, whichever is less. As appropriate, the insured receives a premium credit in exchange for his or her acceptance of additional risk, except in cases in which a mandatory deductible applies.

VI. *Policy Periods*

Policies may be written for any period of less than one year, up to and including one year, or more than one year, at the discretion of the Company.

VII. *Rates and Premium Calculation*

A. Rates, as presented in this manual and/or the applicable rate filings, apply on an annual basis to each individual insured or entity.

B. Additional Charges: The additional charges provided under the classifications in this manual measure the liability of the insured for increased levels of exposure. Additional charges shall be obtained only where coverage for such exposures is provided.

C. Calculation of Premium: One-Year Policies: The premium shall be determined on the basis of the units of exposure existing at policy inception.

D. Calculation of Premium: Short-Term Policies: The premium on policies written for a period of less than one year shall be computed on an annual basis, and the pro rata premium will be charged for the policy period.

E. Refer to the Company for: Agents should refer to the Company any risk meeting one of the following criteria: a) Any risk or exposure for which there is no manual rate or applicable classification, or b) Risks developing annualized premium of $100,000 or more for basic limits for individual (A) rating.

VIII. *Cancellations*

A. By the Insuring Company: The earned premium shall be determined on a pro rata basis by multiplying the number of units of exposure for the period the policy was in force by the applicable rates but shall not be less than the pro rata amount of the minimum premium.

B. By the Insured: Return premium will be computed on a pro rata basis, except as follows. If the insured cancels their policy midterm to obtain coverage from another carrier, while continuing to practice in the same state, their premium will be calculated on a short rate basis.

IX. *Additional Interests*

All additional interests shall be submitted to Underwriting for rating.

X. *Underwriting Procedure: Coverage Options*

Professional liability policies may be written to include (1) individual coverage, (2) entity, partnership, association or corporation coverage, or (3) both coverage types.

XI. *Classification Procedure*

A. For classification assignment purposes, the following phraseology is defined:

1. The term "*no surgery*" applies to general practitioners and primary care specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia) and who do not ordinarily assist in surgical procedures.

2. The term "*minor surgery*" applies to general practitioners and primary care specialists who perform minor surgery (including obstetrical procedures not constituting major surgery) or who assist in major surgery on their own patients.

3. The term "*major surgery*" includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen or pelvis. Major surgery also includes any other operation that because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life. It also includes removal of tumors, open bone fractures, amputations, abortions, cesarean sections, the removal of any gland organ, plastic surgery, and any operation done using general anesthesia.

4. Dentists' classifications are based on the types of procedures that the dentist performs, as well as the location in which the dentist performs those procedures. The Dentist Class Pages provide a description of the classification assignment for dental procedures by location and sedation methodology.

5. Other ancillary healthcare professional classifications are based on the type of professional services being provided. This includes, but is not limited to, nurses, podiatrists, chiropractors, optometrists, psychologists, etc. See Rate Pages for appropriate description of ancillary healthcare professionals.

NOTE: The Classification Pages provide the classification procedures for the various specialties.

B. When two or more classifications are applicable to a general practitioner or specialist, the rate for the highest-rated classification shall apply.

C. Healthcare Providers in active United States military service: The classification section in this manual does not apply to healthcare providers in active United States military services.

D. Healthcare Providers employed full time by the Federal Government but not in active United States military service: The classification section in this manual does not apply to healthcare providers employed full time by the Federal Government (not military service).

XII. ***Extended Reporting Coverage (Tail Coverage) -- Applies To Claims-Made Policies Only***

A. General Instructions: When coverage under this policy ends (whether by nonrenewal or cancellation), the insured has the right to purchase an optional extension of coverage called an Extended Reporting Coverage. The Extended Reporting Coverage will be added to the policy by attaching the appropriate endorsement to the insured's policy.

B. Scope of Coverage: The Extended Reporting Coverage will extend the insured's coverage to include all valid claims that: (1) began on or after the retroactive date and prior to the cancellation or non-renewal date; and (2) are reported to the Company during the time period the Extended Reporting Coverage is in effect.

C. Extended Reporting Coverage Payment Options: When coverage under this policy ends, an insured may purchase Extended Reporting Coverage using the annual or quarterly payment options. Exceptions may be considered on a case-by-case basis.

Any nonpayment of these premiums will result in the Extended Reporting Coverage being canceled, and we will not provide further coverage.

D. Request Notification: The option to purchase the Extended Reporting Coverage must be exercised by the named insured by written notice to the Company within thirty (30) days after termination of the policy. Subsequent premium payments must be made by the premium due date of the endorsement, or the endorsement will terminate. There is no grace period built into the premium due dates.

E. Limits of Liability: The limits of liability that apply to the extended reporting period will be the same as, and included in, the limits in effect on the expiring policy. The limits of liability cannot be increased from those on the canceled or nonrenewed policy.

The aggregate limit stated on the Extended Reporting Coverage is the most we will pay for all claims first received by the insured and reported to the Company during the period of the endorsement. In states where limits of liability are statutorily specified, if the period of the endorsement is for more than one year, the total limit applies separately to each annual period, as required by state statute, beginning with the date the endorsement takes effect. In other states where limits of liability are *not* statutorily specified, if not required by state statute, the total limit may apply to the entire extended reporting period shown on the endorsement.

F. Premiums: The premiums for the extended reporting period will be set by the Company in accordance with the rules, limits and rating plans in effect on the date the coverage is to be effective.

To determine the appropriate charge for Extended Reporting Coverage, we must determine the appropriate specialty and risk classification, calculate the period of time during which coverage existed under the claims-made policy, and apply these factors to our rating model to determine the appropriate premiums.

G. Fully Paid-Up Tail Benefit: If the insured meets any of the following conditions, he or she will receive the Death, Disability and Retirement (DDR) Extended Reporting Coverage at no additional cost:

1. Death:

2. Permanent and total disability that renders the insured completely unable to continue his or her practice;

3. Full retirement from practice (any specialty) and completion of at least five (5) continuous years coverage with us, ending on the date of retirement.

Before we issue such an Extended Reporting Coverage, we will require proof of eligibility from the insured.

The DDR Extended Reporting Coverage will become effective at the end of the policy period during which the insured meets one of the preceding conditions and will provide a new set of coverage limits and an unlimited extended reporting period.

H. Resumption of Practice: If at any time in the future the insured resumes his or her practice to any extent, any Extended Reporting Coverage issued pursuant to Sections XII.G or XII.H will terminate as of the time the insured resumes his or her practice.

The insured will then have the right to purchase Extended Reporting Coverage upon payment of the proper premiums, in accordance with the terms of our policy.

I. Eligibility: Any healthcare provider or entity insured under a primary policy issued by the Company is eligible for and entitled to purchase Extended Reporting Coverage.

XIII. ***Partnership, Professional Corporation or Professional Association Coverage***

Partnerships, professional corporations (including solo corporations), or professional associations may receive a primary insurance policy at the option of the insured (unless required by law) at a charge that is based on the net premium charge for the individual healthcare providers of the entity, provided that the Company insures all principals as individuals. (See Manual Page A) Exceptions to this "all-or-none" rule may be made at the Company's discretion. The minimum premium charge for this coverage is $100. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association.

XIV. ***Employee Professional Liability Coverage***

A. Definitions: Employees (other than a physician or resident) are covered under an insured's policy if they are employed by the named insured and are acting within the scope of their duties as such. Refer to the policy for the definition of employees.

B. Limits of Liability: Such employees share in the limits of liability with their employer. They do not receive their own individual limits of liability. In some cases, individual limits of liability are available for employees at an additional charge. See Rate Pages.

All other manual rates are applicable.

XV. ***Prior Acts Coverage -- Applies To Claims-Made Policies Only***

For insureds who have been covered under a claims-made policy with another insurance carrier, we can offer Prior Acts Coverage, subject to underwriting approval. Prior Acts Coverage will recognize the insured's retroactive date under the previous policy. However, special rules for claims apply to Prior Acts Coverage, as specified in the most current policy form.

Prior Acts Coverage is limited to activities in those states where PIC Wisconsin is licensed to write professional liability coverage, or where we are legally allowed to and have agreed to do so. If we are unable to provide Prior Acts Coverage due to licensing or underwriting restrictions, the insured must obtain Extended Reporting Coverage for that exposure from their previous carrier. Rating for Prior Acts Coverage is based on the same criteria as the insured's base coverage, including retroactive date, specialty classification and other applicable factors as described throughout this Rule and Rating Manual.

XVI. *Reunderwriting Rating Mechanisms: Rules and Risk Characteristics*

Through an automated process, individuals who fall into the following categories will be identified for a reunderwriting review:

- Claims Severity: Any claim that is $50,000 or higher (reserve or indemnity paid) for physicians or surgeons, and $10,000 or higher for other healthcare providers or practitioners.

- Claims Frequency: (1) Two claims with paid indemnity (or open with reserves established) within a three-year period, or (2) five claims of any kind within a five-year period.

On the basis of Underwriting's review, the individual may be subject to a risk management advisory letter, a surcharge or practice limitation, a mandatory deductible or, if necessary, nonrenewal.

A. Surcharge and/or Coverage Exclusion

The surcharge mechanism will be used to account for claim severity, although it could be used for claim frequency, as identified through a review of the insured's claim file, through discussions with the claim examiner and evaluation of expert medical reviews. This surcharge system involves the assessment of a predetermined surcharge scale. (See Manual Pages.)

The five-year evaluation period is calculated on a calendar-year basis, retroactive from January 1 of the policy year in which the review is being conducted.

B. Mandatory Deductible

The deductible mechanism may be applicable when a policyholder exhibits a pattern of claim frequency that exceeds the average for his/her specialty. In the consideration of a deductible assessment, severity is usually not an issue.

Deductibles may be imposed in amounts from $1,000 to $250,000 per claim. There is no corresponding premium discount, and there are no aggregate limits on mandatory deductibles.

An amendatory deductible endorsement will be added to the policy at renewal and will be maintained for no less than one year. The policy will be subject to an annual review thereafter for consideration of a revised sanction.

XVII. Rate Adjustments for Changes in Exposure – Claims-made, Retroactive and Reporting Endorsement Coverage

A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,

2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,

3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

Gynecology rate for claims-made year five,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads,

additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

C. Reporting Endorsement Coverage

If reporting endorsement coverage is to be rated, the same method is utilized, substituting the reporting endorsement rates for the claims-made rates. For example, a reporting endorsement purchased at the end of the second year of gynecology practice in the obstetrics/gynecology example described above would be:

Gynecology reporting endorsement premium for claims-made year two,
plus OB/GYN reporting endorsement premium for claims-made year five,
less OB/GYN reporting endorsement premium for claims-made year two.

D. Occurrence Coverage

The calculations for changes in exposure are performed by prorating the rates for the periods of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

XVIII. *Voluntary Deductibles*

In exchange for a reduction in their premium, some insureds opt to accept a portion of the risk. The Company maintains responsibility for making indemnity payments on the insured's behalf, up to the limits defined in the policy. However, the insureds who select a deductible option agree to reimburse us up to the deductible amount specified on their Declarations, Coverage Summary or any Deductible Endorsement.

Refer to the state programs section of the manual for the applicable deductible credits.

HEALTHCARE PROVIDERS
PROFESSIONAL LIABILITY
MANUAL PAGES

• ***Healthcare Entities, Partnership, Professional Corporation or Professional Association Coverage***
Healthcare entities, professional corporations, associations or partnerships (including solo corporations) may receive a primary policy at the option of the insured (unless required by law) at a 0 - 10 percent charge, unless specified in the State Program pages, that is based on the net premium charge for the individual insured healthcare providers of the entity, provided that the Company insures all principals and employed healthcare providers as individuals. The covered entity will receive a separate set of limits for the 0 - 25 percent charge, unless where specified in the State Exceptions pages. The minimum premium charge for this coverage is $100. However, this minimum premium may be waived for a specific market or program applying to eligible members of an association.

• ***Employee Professional Liability***

Professional employees (other than nurse anesthetists, certified nurse midwives, physicians, residents, surgeons or dentists) of a partnership, professional corporation, professional association or an individual practitioner may be included under policies issued to their employers at no additional charge. The employees' limits of liability will be shared with the named insured, unless separate limits of liability are purchased. These employees may also receive their own individual policy with separate limits of liability, dependent on the scope of their practice.

Additional Professional Employee Charges
If the professional employee shares in the limits of liability with their employer, the following additional charges will be added to the named insured's policy, as appropriate.

• Physician or Surgeon Assistant: 80116
No Additional Charge.

• Certified Nurse Midwives:
Refer to rate page for Ancillary Coverages.

• Advanced Practice Nurse Prescribers:
No Additional Charge.

• Vicarious Liability for Contract Healthcare Providers:
The rate for vicarious liability for contract healthcare providers will be 10% of the mature claims-made rate, regardless of maturation, or 10% of occurrence, depending on the policy, for the self-employed healthcare provider. The additional charge does not apply if the employer/ full-time contractor is also insured by our Company.

• Vicarious Liability

Any employer may be vicariously liable for the acts of an employee. In the case of a health care provider not insured by PIC Wisconsin due to underwriting reasons (failure to cooperate with risk management, claims history, etc.), the employer will be charged 10% of the rate applicable for that health care provider. That is 10% of the mature claims-made rate, regardless of maturation, or 10% of the occurrence rate, depending on the policy. Exceptions can be made and the charge waived if:

- A health care provider is eligible for coverage with PIC but elects to obtain coverage from another carrier; or
- A health care provider is close to retirement and would receive an Extended Reporting Coverage at no charge from another carrier.

If the professional employee received his or her own policy and separate limits of liability, the following rates will be added to their own policy:

• Physician or Surgeon Assistant: 80116

See Ancillary Coverage Charges, as filed with the Department of Insurance. The rate per physician or surgeon assistant will be 15 % of the mature Class I rate or the rate shown on the rate page, as filed with the Department of Insurance.

• Certified Nurse Midwives:

See Ancillary Coverage Charges, as filed with the Department of Insurance. The rate per certified nurse midwife will be based on the Class I rate, as filed with the Department of Insurance.

• Advanced Practice Nurse Prescribers:

See Ancillary Coverage Charges, as filed with the Department of Insurance. The rate per advanced practice nurse prescriber will be 15 % of the mature Class I rate or the rate shown on the rate page, as filed with the Department of Insurance.

• ***Emergency Medicine Part-Time***

Physicians working in the emergency room to supplement their income or as a requirement for hospital privileges may work a maximum of 15% of their practice time without increasing their classification to Emergency Medicine.

Any physician working 16 % or more of his or her scheduled practice time in the Emergency Room will be classified as Emergency Medicine (Code 80102), unless the physician also practices in a specialty that is in a higher rated classification than Emergency Medicine, then the premium will be based on the rates for the higher classification.

• ***Moonlighting Residents***

Residents who work part-time for a corporation, a clinic or another healthcare provider will be assigned the appropriate classification code, in accordance with our underwriting guidelines. Refer to rate page for Ancillary Coverages.

• ***Locum Tenens Coverage***

Coverage for temporary substitute health care providers may be provided through the issuance of an Additional Insured endorsement or the Locum Tenens Endorsement. In states not requiring a separate set of limits for the substitute, the Locum Tenens health care providers will be added to the insured's policy as an additional insured, sharing in the insured health care provider's limits. In states requiring separate limits for each health care provider, a Locum Tenens endorsement will be added to the insured health care provider's policy, providing a separate set of temporary limits to the Locum Tenens. Locum tenens coverage should not exceed a period of 90 days.

To cover the processing and administrative costs involved, a $50 minimum premium charge per Locum Tenens endorsement may be applied. At underwriter's discretion, the processing charge may be waived if the Locum Tenens physician has been covered within the previous 30 days.

• ***First- and Second-Year Practitioner Credit***

Any healthcare provider just entering private practice who has finished his/her formal education within the preceding year may be classified and rated in accordance with his/her specialty with the following credits:

Description	Modification Factor
1st-year New Healthcare Provider	0.50 times the appropriate first-year claims-made rate
2nd-year New Healthcare Provider	0.75 times the appropriate second-year claims-made rate

Note that these discounts do not apply to occurrence rates. Please note State Exceptions pages for specific state rules.

• ***Teaching Credit***

A healthcare provider who spends a minimum of 40 percent of his/her practice time teaching (non-clinical) will be classified and rated by the following method:

Description	Modification Factor
Use appropriate specialty code description	0.75 times the appropriate claims-made rate

• ***Limited Practice (Not available in Nebraska)***

The rate for healthcare providers who are eligible for the Limited Practice benefit (practicing an average of 20 hours per week or less) will be 50% of the applicable claims-made premium that corresponds to the period of time during which the healthcare provider practices on a limited basis. Refer to Underwriting for eligible specialties. The healthcare provider's premium will still account for any previous exposure that the healthcare provider faced, in accordance with our rating model. For occurrence policies, the 50% discount applies to the pro rata premium from the date Limited Practice is added through the expiration date, if added mid-term. For occurrence policy renewals or new business or other policies with Limited Practice from inception to expiration, the premium is reduced by 50%. Please note State Exceptions pages for specific state rules.

• ***Suspension of Coverage (Not available in Nebraska)***

The rate for healthcare providers who are eligible for the Suspension of Coverage benefit will be 0 percent of the applicable claims-made premium that corresponds to the period of time during which the healthcare provider suspends coverage. The healthcare provider's premium will still account for any previous exposure that the healthcare provider faced.

The Suspension of Coverage provision in the Exposure Reduction Endorsement will indicate the date on which the healthcare provider anticipates to return to practice. For rating purposes, this date will serve as the ending date of the suspension of coverage period. However, if the healthcare provider actually returns to active practice on a date that differs from this indicated date, we will adjust the premium to reflect the actual ending date of the suspension period. Upon returning to practice, the healthcare provider will receive an Amendatory Endorsement that will clearly specify the period of suspension of coverage. Please note State Exceptions pages for specific state rules.

• ***Anesthesiologist's Program***

Anesthesiologists and certified registered nurse anesthetists (CRNAs) who indicate that they utilize a pulse oximeter and an end-tidal CO2 analyzer in the administration of anesthesia will be rated at 60 percent of the applicable claims-made premium. It is assumed that this equipment is being utilized, and the credit is built into the manual rate. If the equipment is not used, a surcharge will be applied to the premium for the insured that does not utilize this equipment.

• ***Schedule Credit / Debit Program***

To recognize the unique risk characteristics of our insureds, we may apply debits or credits that reflect the nature of a particular insured's practice. The maximum deviation available under this program varies by state. See unique state program pages per state.

Credits for insureds will be determined on the basis of our evaluation of each insured's risk profile. This assessment may consider such characteristics as loss experience, management, employees, patient medical records, quality assurance, facilities and billing procedures, and other criteria, as appropriate. This program only applies if a schedule rating plan is shown in this manual for the applicable market.

• ***Rate Adjustments for Changes in Exposure – Claims-Made, Retroactive and Reporting Endorsement Coverage***

A. Claims-Made Coverage

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the *current* practice patterns began,

2. plus rate for prior practice, determined using a retroactive date equal to the date that the *previous* practice patterns began,

3. less rate for prior practice, determined using a retroactive date equal to the date that the *current* practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

For example, if a physician had practiced obstetrics and gynecology for many years, then stopped practicing obstetrics and began to practice gynecology only, the appropriate premium for the upcoming policy period would be:

Gynecology rate for claims-made year one,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year one.

This produces a blended rate, reflecting the remaining OB/GYN exposure that makes up the majority of the expected reported claims in the upcoming year, plus the initial gynecology exposure.

The rate for the second year of gynecology-only practice would be:

Gynecology rate for claims-made year two,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year two.

This adjustment process continues for two more years, until the beginning of the fifth year in the new specialty. At that time, the blended rate would be:

Gynecology rate for claims-made year five,
plus OB/GYN rate for claims-made year five,
less OB/GYN rate for claims-made year five,

which is simply equal to the gynecology rate for claims-made year five.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

B. Prior Acts Coverage

When prior acts coverage is provided, the same method is utilized, as if the insured had been with the Company during the prior acts period. Practice information regarding the prior acts period is obtained from the insurance application.

C. Reporting Endorsement Coverage

If reporting endorsement coverage is to be rated, the same method is utilized, substituting the reporting endorsement rates for the claims-made rates. For example, a reporting endorsement purchased at the end of the second year of gynecology practice in the obstetrics/gynecology example described above would be:

Gynecology reporting endorsement premium for claims-made year two,
plus OB/GYN reporting endorsement premium for claims-made year five,
less OB/GYN reporting endorsement premium for claims-made year two.

D. Occurrence Coverage

The calculations for changes in exposure are performed by prorating the rates for the periods of differing exposures. These calculations are appropriate for changes in practice specialty, changes in rating territory or practice in other states, changes between part-time and full-time practice, and other changes that would affect a calculated rate. Currently approved rates, classification tables and discount or surcharge factors for the appropriate state(s) are used.

Although this method of adjusting rates is designed to accommodate most situations, changes in medical practice often result from increasing or decreasing patient loads, additional medical training, relocation of the practice, gradual reduction in practice nearing retirement and other underwriting factors which affect the risk of loss. As a result, the Company may choose to waive the exposure change adjustment process in specific situations, thereby utilizing the current rating variables without modification. Conversely, a debit under the Scheduled Rating Plan may be applied at the underwriter's discretion, based on more than five years of practice in specialties with long claim emergence patterns, such as Pediatrics or Obstetrics.

• ***Group Practice Modification Plan (not available in Nebraska)***
Credits for groups will be determined annually on the basis of our evaluation of each individual group's risk profile, which assesses such characteristics as changes in maturity, number of healthcare providers, specialty composition, management, employees, patient records, quality assurance, facilities, billing procedures and loss history. See Unique State Programs pages for specific debit and credit allowance.

Group Practice Eligibility

1. a. For a group of physician healthcare providers, five or more permanently licensed, practicing physicians, or two or more physicians that generate a combined premium of $50,000 annually after all other premium modifications have been applied (but prior to the application of the "group practice modification plan.")

   b. For a group of dental healthcare providers, two or more permanently licensed, practicing dentists.

   c. Other markets are not eligible for group practice (entity) policies or rating, unless specifically addressed in this manual.

2. Group must be a corporation, partnership, joint venture, or limited partnership association.

3. Primary location where both professional services are rendered and administrative functions (billing, patient records) are undertaken.

4. Satellites are acceptable to the extent they are controlled and are practicing as part of the primary location.

5. The entity must be organized for the purpose of delivering professional services to patients.

6. The applicant should have a favorable loss history over the preceding five-year period. Evaluation will be based on the size of the group, the number of paid and pending losses and the severity of the losses.

Group Practice Primary Evaluation Criteria

1. Length of time entity has operated as a group.
2. Degree of specialization within the group.
3. Stability of members and locations.
4. Reputation and standard within the community served.
5. Promotional materials, advertising, sign on the door.
6. Hospitals where healthcare provider(s) has admitting privileges.

Group Practice Risk Profile

This risk profile should ascertain the level of the group's involvement and commitment in their effort to provide risk management. It is the Company's philosophy that the greater effort clinics use to reduce risk, the more awareness they have of methods to limit the exposure to malpractice litigation. If properly instituted, a good risk management program will:

1. Reduce the risk of malpractice claims by the recognition and elimination of problem areas;
2. Augment a defensible position;
3. Increase awareness of potential areas of risk;
4. Improve the standard of care;
5. Provide a mechanism for patient advocacy.

Group Practice Claims History Evaluation

This evaluation ascertains the level of the group's prior claims and loss history and to obtain the appropriate claim information and assess the liability, if any, of a healthcare provider. To make the assessment, identify the following factors:

1. Did the healthcare provider depart from the accepted standard of care? Did that departure result in injury, loss, or damage to the patient?
2. What was the opinion of the peer review committee, if any, or experts who reviewed the case as to the standard of care rendered?
3. Are there any patterns or trends noted in the healthcare provider's practice which could give rise to subsequent professional incidents, such as the same surgical procedure improperly performed, inadequate patient histories or workups, lack of informed consent, improper record keeping and documentation, etc.?
4. Assess the number of claims which have occurred from inception of the healthcare provider's practice. Evaluate those that have occurred against the nature of the insured's specialty. For example, an emergency room physician is exposed more frequently due to the nature of that specialty – treatment of trauma injuries.
5. If a renewal, review the claim representative's case summary, trial review or other evaluation report for their assessment of the merits of the case. Often the Litigation Specialist is in contact with the healthcare provider and is the most knowledgeable of the facts in the case. Did the healthcare provider cooperate with the Litigation Specialist and the Company in preparing the defense?

Upon evaluation of these factors, either a decision or a recommendation for coverage will be formed by the Underwriter. If necessary, the case will then be reviewed by the appropriate peer review committee or Underwriting Advisory Committee for acceptability based on adherence to the standard of care.

Non-Group Primary Evaluation Criteria

1. Length of time healthcare provider(s) has practiced;
2. Stability of practice;
3. Reputation and standing within the community served;
4. Hospitals where healthcare provider(s) has admitting privileges;

Non-Group Risk Profile

This risk profile should ascertain the level of the healthcare provider's involvement and commitment in their effort to provide risk management. It is the Company's philosophy that the greater effort healthcare providers use to reduce risk, the more awareness they have of methods to limit the exposure to malpractice litigation. If properly instituted, a good risk management program will:

1. Reduce the risk of malpractice claims by the recognition and elimination of problem areas;
2. Augment a defensible position;
3. Increase awareness of potential areas of risk;
4. Improve the standard of care;
5. Provide a mechanism for patient advocacy.

• Independent Medical Exams (IMEs)

Physicians performing the IMEs are generally retired and face a limited amount of exposure from IMEs. Accordingly this "per IME" rating methodology more appropriately reflects the actual risk that these physicians face.

Following is the calculation process for rates per independent medical examination:

> Number of IMEs X 2 hours per IME / 2304 (the hours worked to be considered full time)= Number of full time equivalents. The number of full time equivalents is multiplied by the occurrence rate for legal medicine to determine the total premium based on full time physicians. This premium is divided by the number of IMEs to determine the rate per IME. The average number of IMEs performed by those in the program is multiplied by the rate per IME to get the premium per physician in the program, subject to the minimum premium of $550 / physician.

The insured has the option of making this program audited (based on the actual number of IMEs performed, subject to the minimum premium per physician) or non-audited.

The total premium will be computed by multiplying the number of annual IMEs by this derived rate. The total premium value is also subject to a minimum premium of $550 per physician. Likewise, the corporate premium -- which is based on 2% of the mature Class I-A rate multiplied by the total Full-Time Equivalents -- is subject to the minimum premium of $500.

• Loss Free Discount Program

> Loss-Free Credit: Healthcare providers who have not experienced losses may be able to receive premium credits in accordance with our established guidelines. Loss-free credits are earned in annual increments as shown on the state pages.
>
> Definition of a Meritorious Claim: If any one claim results in an indemnity payment of more than $10,000 for physicians, or $3,000 for all other healthcare providers, the premium for the healthcare provider will revert to the base level. Otherwise, loss-free credits will continue to apply and accumulate, subject to the maximum available credit, as well as Underwriting review.
>
> If a Loss (As Defined) Occurs After Enrollment Into the Program: In this situation, the rates upon renewal revert back to the 100 percent level until the health care provider has been loss free for a full policy year, at which time credits again begin to accumulate.

- *Affinity Group Discount Program*

An affinity group is a group of people who are within the same geographic community or the same specialty, or both. This program is a form of participation credit for insureds who have a common relationship – the same specialty or the same geographic region, using the same purchasing agent or broker. If more members in the purchasing group or specialty group participate in the Company's programs, they may qualify to receive a higher affinity di scount percentage.

An affinity group is similar to a credit union, a cooperative organization that provides special benefits or discounts to its members, who all share some unique characteristic to be eligible for membership. An example of this in the medical malpractice insurance world would be a group of 25 anesthesiologists practicing as individual physicians but use the same purchaser or broker for billing services or insurance purchasing power, forming an insurance purchasing group. Another example would be members of the State Medical Society as the affinity group, and a ten-member group practice would be a subgroup with that larger affinity group.

Affinity groups must have at least 2 or more independent practices/customers (solo or multiple as part of the same corporation) and consist of at least 25 total insureds. Each member continues to have their own policy and individual premium components, but can receive the affinity discount due to their common relationship as a part of such an affinity group.

Participation discounts would be based on the number of physicians in the "group" and the specific composition of that "group". The participation discount for all members of the affinity group will be determined at one time during the year, and will remain at that level until the anniversary date the following year. All changes are based on the discount in effect on the renewal/anniversary date. The new discount is applied to participating members at renewal. All other participating members will receive the discount on their own individual renewal/anniversary date.

A customer that is in multiple affinity groups can only purchase his/her PIC WISCONSIN Medical Professional Liability through one affinity group at a time, receiving only one affinity discount.

Refer to state program manual pages for participation discounts, based on the number of members.

• **Risk Management Modification Plan**

		Total Credit/Debit
A.	APPROVED PROGRAMS, INCLUDING SELF STUDY KITS OR SEMINARS - Evidence of completed seminar agenda or outline, completed within a reasonable timeframe - Complete approved self-study kit	5 - 15%
B.	EXISTING RISK MANAGEMENT PROCEDURES IN PLACE Risk Management Survey	10-15%

Maximum modification based on A and B above is 25%.

NOTES:

A. To receive credit for attending an approved Risk Management seminar:
   1. It must have been attended within an acceptable timeframe of the inception date of the policy.
   2. It must be a seminar that is approved as a Risk Management Seminar, relating to Risk Management topics including, but not limited to, informed consent or medical records. Information, such as a brochure or flyer describing the seminar, is necessary to determine this.
   3. We must receive evidence of attendance, such as a certificate of completion.
   4. To receive credit for the self-study program, a test or other evidence of completion must be presented to PIC Wisconsin.

B. To receive credit for procedures in place, the appropriate general, anesthesiology, radiology, or emergency medicine form must be completed. The categories of questions reviewed in these surveys include, in order of weighted importance: Medical Records (45% weight), Patient Management (15% weight), Informed Consent (15% weight), Patient Relations (15% weight), Employee Management (5.0% weight) and Regulatory Compliance (5% weight).

Summary of Credits Available for All Markets, All States

Please refer to State Programs Pages for each individual state's credit listings.

ILLINOIS PROGRAMS

The following amends the preceding General Rules and Manual Pages and reflects programs that may be available for health care providers in Illinois.

GENERAL RULES

I. General Instructions

The date indicated upon each page of the rules, classifications and rates in this manual do not necessarily reflect the effective date.

Coverage that is provided on or after the effective date (either by endorsement of outstanding policies or by the issuance of separate policies) will be written on the basis of the rates and rules in effect at the time of the change.

VI. Policy Periods

Policy periods will be consistent with requirements in 215 ILCS 5/143.13.

XII. Extended Reporting Coverage (Tail Coverage) Applies to Claims-Made Policies

B. Scope of Coverage

When coverage under the claims-made policy ends (for any reason) the Company will offer the insured an extension of coverage called Extended Reporting Coverage. If purchased, the Extended Reporting Coverage will extend the insured's coverage to include all valid claims that:

(1) began on or after the retroactive date and prior to the cancellation or non-renewal date; and

(2) are received by the insured and reported to the Company during the time period the Extended Reporting Coverage is in effect.

The Extended Reporting Coverage will be added to the policy by attaching the Extended Reporting Coverage Confirmation Endorsement.

In some instances, the insured may wish to limit the cost of their Extended Reporting Coverage by limiting the term of the endorsement.

Reporting Period Options:
Unlimited Reporting Period:
An unlimited extension of time is provided for reporting claims

12 Month Reporting Period
Claims reported within 12 months after the date the reporting endorsement is issued

24 Month Reporting Period
Claims reported within 24 months after the date the reporting endorsement is issued

36 Month Reporting Period
Claims reported within 36 months after the date the reporting endorsement is issued

C. Extended Reporting Coverage Payment Options: When coverage under this policy ends, an insured may purchase Extended Reporting Coverage using the annual or quarterly payment options. Exceptions may be considered on a case-by-case basis.

Upon payment of premium due, the Extended Reporting Coverage cannot be cancelled.

D. Request Notification

The option to purchase the Extended Reporting Coverage must be exercised by the named insured by paying the minimum premium due for the Extended Reporting Coverage within thirty days after the cancellation or non-renewal of the policy.

F. Premiums

The charge for this coverage for Medical Professional Liability will be the **Expiring Annual Premium** of the policy multiplied by the appropriate Tail Factor shown below:

Physicians		Dentists	
Claims Made Years	Tail Factor	Claims Made Years	Tail Factor
1	4.7	1	2.048
2	4.25	2	1.738
3	2.5	3	1.568
4	2.5	4	1.499
5	2.526	5	1.439
6	2.461		
7	2.4		

For the purpose of this calculation, **Expiring Annual Premium** means the annual premium invoiced to the insured, plus any first or second year discounts that were deducted from the actual premium.

The premium for the optional reporting periods described above will be based on the charge shown above multiplied times the following factor:

Unlimited Reporting Period	1.00
12 Month Reporting Period	0.45
24 Month Reporting Period	0.75
36 Month Reporting Period	0.85

XIII. Partnership - Corporation - Professional Association Coverage

Coverage for partnerships, corporations, or professional associations may be written with a separate limit of liability. The premium charge will be a percentage (selected from the table below) of the sum of each member physician's net individual premium. For each member physician not individually insured by the Company, a premium charge will be made equal to 30% of the appropriate specialty rate if the Company agrees to provide such coverage. In order for the entity to be eligible for coverage under the separate policy, the Company must insure all member physicians, or at least 60% of the physician members must be insured by the Company and the remaining physicians must be insured by another professional liability program acceptable to the Company.

	$1M/$3M Charge			$500K/$1.5M			$200K/$600K		
	PRA	IL Prop.		PRA	IL Prop.		PRA	IL Prop.	
# of Insureds	Std.	Phys	Dental	Std.	Phys	Dental	Std.	Phys	Dental
1	N/A	N/A	5.0%	N/A	N/A	N/A	N/A	N/A	N/A
2 - 5	15.0%	N/A	5.0%	18.0%	N/A	18.0%	23.0%	N/A	23.0%
6 - 9	12.0%	N/A	5.0%	17.0%	N/A	17.0%	21.0%	N/A	21.0%
10 - 19	9.0%	N/A	5.0%	13.0%	N/A	13.0%	17.0%	N/A	17.0%
20 - 49	7.0%	N/A	5.0%	9.0%	N/A	9.0%	13.0%	N/A	13.0%
50 or more	5.0%	N/A	5.0%	7.5%	N/A	7.5%	10.0%	N/A	10.0%

• ***Partnership - Corporation - Professional Association Extended Reporting Endorsement Coverage***

Partnerships, corporations, or professional associations that purchase a separate limit of liability may be eligible to purchase an Extended Reporting Endorsement upon cancellation of the coverage. For the entity to be eligible for the separate limit extended reporting endorsement, all physician members insured on the policy must exercise their right to purchase an individual extended reporting endorsement. The premium charge for the entity extended reporting endorsement will be a percentage of the sum of each member physician's net individual reporting endorsement premium, based on the number of insureds and the table in the Paragraph above.

• ***Quarterly Installment Options***

1. Quarterly Installment Option One
   a. A minimum initial deposit required, which shall be 40 percent of the estimated total premium due at policy inception;
   b. The remaining premium spread equally among the second, third and fourth installments at 20 percent of the estimated total premium, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

2. Quarterly Installment Option Two – (35/25/25/15)
   a. A minimum initial deposit required, which shall be 35 percent of the estimated total premium due at policy inception;
   b. The remaining premium will be 25 percent for the second and third installments and 15 percent for the fourth installment, and due 3, 6 and 9 months from policy inception, respectively;
   c. No interest or installment charges;
   d. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to the policy shall be billed immediately as a separate transaction; and
   e. The installment plan will be limited to insureds whose premium exceeds $500.00 per year.

XIX. Voluntary Deductibles

Medical Professional Liability Deductible Credits

Deductible credits assume the following:

1. Aggregate deductible of 3 times the per occurrence deductible
2. Deductible is for damages only, not for damages and defense
3. Deductible applies per incident, not per certificate holder
4. Factor is applied to gross PL premium at $1M/$3M limits
5. Excess pricing for deductible accounts is based on premium prior to application of deductible factor

Deductible	Credit % of $1,000,000/$3,000,000 Gross PL Premium
$1,000	1.8% - 2.2%
$2,000	3.6% - 4.4%
$5,000	6.3% - 7.7%
$10,000	8.1% - 9.9%
$25,000	12.6% - 15.4%
$50,000	16.2% - 19.8%
$75,000	20.7% - 25.3%
$100,000	25.2% - 30.8%
$150,000	30.6% - 37.4%
$250,000	36.0% - 44.0%
$400,000	39.6% - 48.4%
$500,000	45.0% - 55.0%

Note: For full limits deductibles, refer to Company

Additional options, multiply times the following factors:

Aggregate 4 times the per occurrence	1.050
Aggregate 5 times the per occurrence	1.075
No Aggregate	1.100
Damages and Defense deductible	1.10 - 1.25
Deductible per certificate holder	1.100

MANUAL PAGES

• ***Schedule Credit/Debit Program***

The maximum deviation available under this program in Illinois is 25% for physicians and dentists.

• ***Loss Free Discount Program (Physicians)***

# Of Loss-Free Years	Annual Credit	Accumulated Credit
1	3.33%	3.33%
2	3.33%	6.66%
3	3.34%	10.00%

New Business: Physicians who have been loss-free (with no indemnity payments) for the past three years will receive the full premium credit of 10 percent. Physicians who have been loss-free for two years will receive a 6.66 percent credit, while physicians with one year of loss-free experience will receive a 3.33 percent credit.

• ***Loss Free Discount Program (Dentists)***

# Of Loss-Free Years	Annual Credit	Accumulated Credit
1	5%	5%
2	10%	10%
3	15%	15%

New Business: Dentists who have been loss-free (with no indemnity payments) for the past three years will receive the full premium credit of 15 percent. Dentists who have been loss-free for two years will receive a 10 percent credit, while dentists with one year of loss-free experience will receive a 5 percent credit.

• ***Affinity Group Discount Program***

Participation discounts, based on the number of members would be:

0 - 25% Participation	1% Discount
26 - 49% Participation	2% Discount
50 - 99 Participation	3% Discount
100% Participation	5% Discount

• ***Group Practice Modification Plan***

The maximum credit or debit is 75 percent for physicians and dentists, based on the eligibility, primary evaluation criteria, risk profile and loss ratio evaluation, as described in the rules pages.

Maximum Credit / Debit Modifications

The maximums available under these programs in Illinois are as follows:

	Group Providers	Individuals
Schedule Credit / Debit Program	NA	25%
Loss Free Discount (physicians)	NA	10% Credit
Loss Free Discount (dentists)	NA	15% Credit
Risk Management Credit/Debit	included in Group Practice Modification Plan	10%
Affinity Group Discount	5% Credit	5% Credit
Group Practice Modification Plan	75%	NA

• ***Dental Board Examination Coverage:***

Dental students taking their licensing examinations will be offered annual occurrence coverage for their exposure while taking a dental licensing board examination. Coverage will be provided at limits of $1,000,000 per incident, $3,000,000 aggregate. The policy definition of Professional Health Care Services referred to in the policy are limited to only those services rendered by the insured during a dental board examination.

A $15 charge per examinee will be charged to cover the exposure for these dental candidates. In addition, if the examinee obtains professional liability coverage with the Company after obtaining his/her license to practice dentistry, the Company will apply this fee as a reduction to the insured's first-year premium. The dentist's first professional policy to insure his/her full-time dental practice must be purchased from the Company in order to receive that $15 reduction.

Dental Professional Liability
Classification Pages

Class I:

Code	Specialty	Sedation Method	Practice Location
50110	General Dentistry	Local/Inhalation	Hospital
50210	Endodontics		
50310	Pedodontics		
50410	Periodontics		
50510	Prosthodontics		
50610	Orthodontics		
50710	Oral Pathology		
50810	Public Health		
50910	N.O.C.*		
50111	General Dentistry	Local/Inhalation	Office
50211	Endodontics		
50311	Pedodontics		
50411	Periodontics		
50511	Prosthodontics		
50611	Orthodontics		
50711	Oral Pathology		
50811	Public Health		
50911	N.O.C.*		
50112	General Dentistry	Local/Inhalation	Both
50212	Endodontics		
50312	Pedodontics		
50412	Periodontics		
50512	Prosthodontics		
50612	Orthodontics		
50712	Oral Pathology		
50812	Public Health		
50912	N.O.C.*		

* Requires Underwriting Approval

Class 1: **Relativity = 1.00 (continued)**

Code	Specialty	Sedation Method	Practice Location
50120	General Dentistry	Intravenous/Intramuscular	Hospital
50220	Endodontics		
50320	Pedodontics		
50420	Periodontics		
50520	Prosthodontics		
50620	Orthodontics		
50720	Oral Pathology		
50820	Public Health		
50920	N.O.C. *		
50130	General Dentistry	General Anesthesia	Hospital
50230	Endodontics		
50330	Pedodontics		
50430	Periodontics		
50530	Prosthodontics		
50630	Orthodontics		
50730	Oral Pathology		
50830	Public Health		
50930	N.O.C. *		

Class 2: **Relativity = 2.00**

Code	Specialty	Sedation Method	Practice Location
50121	General Dentistry	Intravenous/Intramuscular	Office
50221	Endodontics		
50321	Pedodontics		
50421	Periodontics		
50521	Prosthodontics		
50621	Orthodontics		
50721	Oral Pathology		
50821	Public Health		
50921	N.O.C. *		

* Requires Underwriting Approval

Class 2:

Code	Specialty	Sedation Method	Practice Location
50122	General Dentistry	Intravenous/Intramuscular	Both
50222	Endodontics		
50322	Pedodontics		
50422	Periodontics		
50522	Prosthodontics		
50622	Orthodontics		
50722	Oral Pathology		
50822	Public Health		
50922	N.O.C. *		

Class 3:

Code	Specialty	Sedation Method	Practice Location
51000	Oral Surgery	As Appropriate	Hospital
51001	Oral Surgery	As Appropriate	Office
51002	Oral Surgery	As Appropriate	Both
50131	General Dentistry	General Anesthesia	Office
50231	Endodontics		
50331	Pedodontics		
50431	Periodontics		
50531	Prosthodontics		
50631	Orthodontics		
50731	Oral Pathology		
50831	Public Health		
50931	N.O.C. *		

* Requires Underwriting Approval

Physicians Insurance Company of Wisconsin
Dental Professional Liability Rates

Illinois
Effective 2/15/2008

Rating Factors

A. Base Rate (Class 1, Territory 2, Mature Claims-Made, $100K/ $300K): **$592**

B. Classification Relativities:

Class	Relativity
1	1.000
2	2.000
3	6.000

C. Territorial Relativities

	Relativity	
Territory 1	1.47	Cook County
Territory 2	1.00	All Other Counties

D. Claims-Made Maturity Factors

Maturity	All Classes
1st Year	0.330
2nd Year	0.610
3rd Year	0.800
4th Year	0.900
5th Year	1.000
Occurrence Rate	1.170

E. Increased Limits Factors

Limits in 000's	Class 1 and 2
100/300	1.0000
200/600	1.1000
500/1500	1.3300
1000/3000	1.5500

F. Extended Reporting Endorsement Factors

Maturity	All Classes
12 Mos.	0.676
24 Mos.	1.061
36 Mos.	1.255
48 Mos.	1.350
60 Mos.	1.439

G. Rating Algorithms

Claims-Made Rate = Base Rate x Class Relativity x Territorial Relativity x Clms-Made Maturity Factor x Increased Limit Factor

Occurrence Rate = Base Rate x Class Relativity x Territorial Relativity x Occurrence Factor x Increased Limit Factor

Reporting Endorsement Rate = Base Rate x Class Relativity xTerritorial Relativity x Tail Factor x

Physicians Insurance Company of Wisconsin
Dental Professional Liability

Dentists Rating & Excess Factors

Excess Limits Premium Factors

Excess limits premium shall be derived by applying the appropriate factor below to the appropriate primary rate for limits above $1M/$3M primary.

Excess Limit	Factor
$1M	0.0480
$2M	0.0960
$3M	0.1450
$4M	0.1935
$5M	0.2225

These factors are based upon negotiated reinsurance agreements. Deviation from these factors up to 25% based upon negotiated agreements with reinsurers and/or underwriting judgment may apply.